

**You must contact the Wisconsin Division of Public Health at 608-266-5326 prior to specimen submission. Form must be completed, including travel history. For SARS specimens, include the patient consent forms for both RT-PCR and Antibody Testing with specimen(s).**

Patient Information		Submitter Information	
Name (Last, First):		(Your Institution's Agency Number If Known)	
Address:		(Your Institution's Name)	
City:	State:	Zip:	(Your Institution's Address)
Date of Birth:	Gender: M F	(City, State, Zip Code)	
Occupation:		(Telephone Number)	
Your Patient ID Number (optional):		Health Care Provider Full Name:	
Your Specimen ID Number (optional):		WSLH Use Only Study: VI FLU SURV SARS	WSLH Use Only: Bill To: (WSLH Account # 74201)
<b>Specimen Submitted for:</b> <input type="checkbox"/> Avian Influenza Surveillance <input type="checkbox"/> SARS Surveillance <input type="checkbox"/> Other _____			
<b>Date Collected:</b>	<b>Specimen Type:</b> <input type="checkbox"/> Other _____ <input type="checkbox"/> Nasopharynx Swab (dry) <input type="checkbox"/> Nasopharynx Swab (in VTM) <input type="checkbox"/> Combined Throat/Nasopharynx Swab <input type="checkbox"/> Throat Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Nasopharynx Asp. <input type="checkbox"/> Stool <input type="checkbox"/> EDTA Blood (plasma) <input type="checkbox"/> Serum		
<b>Date of Onset:</b>			
General Symptoms		Respiratory Symptoms	
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Fever	<input type="checkbox"/> Nasal Congestion	<b>CNS</b>	
<input type="checkbox"/> Headache	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Encephalopathy	
<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Delirium	
<input type="checkbox"/> Malaise	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Meningismus	
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Cough ( <i>circle one</i> ) <u>productive / nonproductive / barking</u>		
<input type="checkbox"/> Photophobia	<input type="checkbox"/> Crackles		
<input type="checkbox"/> Rash	<input type="checkbox"/> Dyspnea		
<input type="checkbox"/> Mouth Lesions	<input type="checkbox"/> Wheeze		
	<input type="checkbox"/> Pneumonia		
<b>Vaccination History (Influenza):</b> Was patient vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Date Vaccinated:    /    /			
<b>Travel History (Places and dates):</b>			
<b>Was patient hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, where: _____			
<b>WISCONSIN STATE LABORATORY OF HYGIENE USE ONLY</b>			

**WSLH Test Code: To Be Determined On Receipt**